Exhibit 10

22A915984)
CCM W	

INITIAL REPORT

Patient Name:

Redacted

Chaim Number: 33A915984

Date of Birth:

Insurance Company:

Date of Accident: 11/37/08

Statutarm

Initial Evaluation Date: 19/99/08

HISTORY OF CURRENT CONDITION

Date of Onnet: 11/27 2008

Driver Passenger:

Front Spet/ Buck Seat:

Airbag Deployment: Yes/ (10)

Wearing Seatbelt: Yes/100

Type of Auto: Van/Truck/Sedan

sitting or O wish, want to make a O for, sum a saw Truck coming up from behind, did not slow down, gunned he can to get out of the away, four truck but to fee of priviles soo of was con. Follows the sound sum a food, prive over copped. The com. she word, while Back of sony and was. were to chapter, or scorner, he was to the tropped or or scorner, he was to the tropped or or scorner, he was to the tropped of the same son I make

Type of Other Vehicle Involved: 100 TWOK

Type of Collision: Front Engl Rear Engl Driver Side/ Passenger Side

Did Vehicle Hit anything Else after Collision? MD.

Primary Cause of Collision: Tow steven proven som the Div not See Her.

Amount of Damage to Vehicle:

Body Injuries in Vehicle: Head on Steering Wheel/ Dashboard Less of Consciousness: (N) Immediate Pain after Collision: Yes No/ Hours Later/ Next Day Potice Cause to Scene: Yes/No EMS came to scene: Yes/No Transportation to Hospital by Ambulance: Yes/No Anyone Other than Ambulance? Emergency Room Treatment: Krays/ CT Scan/ MRI/ Medicine/ Admitted/ Released/ Kept for Observation Fellow Up: Doctor's/ Testing — San Chro , Rat. scene, Y well, 7% wen. SYMPTOMS New Falls Middlack on Back Pago — watth of D. Unpur Friedd Middlack on Back Pago — watth of D.	
Immediate Pain after Collision: Yes Not Hours Later! Next Day Police Came to Scene: Yes No. EMS came to scene: Yes No. Transportation to Hospital by Ambulance: Yes No. Anyone Other than Ambulance? Emergency Room Treatment: Kraya! CT Scan! MRI! Medicine! Admitted! Released! Kept for Observation Follow Up: Doctor's! Testing — San Chro, Pat. scane, Y went, Ph. wan. SYMPTOMS: Nock Path! Mid Back! In Back Pain — Mathy of D.	Body Injuries in Vehicle: Rend on Steering Wheel/ Dashboard
Police Came to Scene: Yes/No EMS came to scene: Yes/No Transportation to Hospital by Ambulance: Yes/No Anyone Other than Ambulance? Emergency Room Trentment: Xrays/CT Scan/MRI/Medicine/Admitted/ Released/Kept for Observation Follow Up: Doctor's/ Testing — San Chino, an. secure, y were, ?x were. SYMPTOMS: Nock Path/Mid Back/Law Back Pain — Mathy and D.	Less of Consciousness: 100
Transportation to Hospital by Ambulance: Yess No Anyone Other than Ambulance? Emergency Room Treatment: Xrays/CT Scan/MRI/ Medicine/ Admitted/ Relessed/ Kept for Observation Follow Up: Dector's/ Testing — San Chino, Rel. scare, Y well, 74 was. SYMPTOMS: Note Fath/ Mid Back/ by Back Rain — Mathy of China	
Transportation to Hospital by Ambulance: Yes No Anyone Other than Ambulance? Emergency Room Treatment: Xraya/CT Scan/MRI/ Medicine/ Admitted/ Released/ Kept for Observation Follow Up: Dector's/ Testing — San Chino, Rel. scare, Y well, 74 was. SYMPTOMS: Nucleon Mid Back/ by Back Raio — Mathy of Chino.	office Cause to Scene: Kes/(N) - med at tour free yand
Anyone Other than Ambubance? Emergency Room Trentment: Xrays/CT Scan/MRI/ Medicine/ Admitted/ Released/ Kept for Observation Follow Up: Doctor's/ Testing — Saw Chiro, an. secure, y well, ?x wen. SYMPTOMS: Nuck Path/ Mid Back/ by Back Pain — Mustby of	A
Emergency Room Trentment: Xraya/CT Scan/MRI/ Medicine/ Admitted/ Released/ Kept for Observation Fellow Up: Dector's/ Testing — San Chro, an. scane, y week, 7x was. SYMPTOMS Nock Fath/ Mid Back/ by Back Pain — mutby a	ransportation to Hospital by Ambulance: Yes/No
Fellow Up: Dector's Testing — San Chiro, an. scare, y were, & were. SYMPTOMS Nock Facts Mid Backs on Back Page — Mustby a	syone Other than Ambulance?
Nock Factor Wild Back Days - Mustby a O	mergency Room Trentment: Xrays/ CT Scan/ MRI/ Medicine/ Admitted/
Nock Faith Mild Back Day Back Page - mutty a	illow Up: Dector's Testing - San Chro, Rr. secure, 4 well, 7% wen.
Numbress Tingling Cohi/ Right Lery Both Hands: Fingers:	per Extremity abbased Tingling Cohl Right Leri Both
Numbers Tinglist Cold / Right Led Both Buttocks Feel Toes	Hours Cinglish Cold / Right (Left Both
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Headuches: Ves No Dizziness/ Memory Loss: Frequency: every day. Bowel Bladder Dysfan: Jaw Poin/ Tinnitus: Head Pain/ Elbow Pain (R/L)/ Knee Pain(R/L)/ Ankle Pain (R/L) / Fost Pain (R/L) Abdominal Palm: Location: Chest Pain: Location: PREVIOUS MEDICAL HISTORY Asthma/ Diabetes/ Cancer/ Hypertension/ Heart Disease/ High Cholesterol: Soe mediand History Form Acute/ Chronic Medical Condition: Previous Surgeries: Previous Auto/ Work Accidents: Year: 7003 Creatment for Anto/ Work Accident: MRI/ CT/ Surgeries - saw throops was pr, @ slear por. Resolved/ Not Resolved: SOCIAL HISTORY Married/Divorced/ Widowed/ Single/ Separated

Ages:

Live At Home/ Away: /

Children:

Smoke: Yes/No Alcohol: Yes No How much: Recreational Drugs: Yes No How much: How much: **EMPLOYMENT** Employed at the time of Accident Yes No Currently Employed Yel No Date of Last Employment: Curtost Employer: petro. I made Partnersty Job Title News piper relien Other: PHYSICAL EXAM-APPEARANCE White Black: Height: 5 4 Weight: 132 Right Handed/ Loft Handed: Difficulty Standing Yes No Notes

	Out of Chair Pey No
Notes: NECK EXAM:	
Neck Spanns Yes No	o Right Side Left Side Suboccipitals
Water to the same of	prefitor Right Lateral Figs. / ILEN Lateral Flex) Right Lett
	rogth: Right' Loft Upper Extremity
Decrease Grip Strengt	gth: Right/ Left Upper Extremity
Curvical Compression	n Test: 🗐 -
Cervical Distraction T	Kest: 🔗-
Shoulder Depression 1	Test: (4)-
Valsalva's Test: 📆	•
Paluatory Tenderness:	R.
C-Spine: DD D D C T-Spine: D B B 4	ව ලෙද ව ලබු වුණු 10 1% 12
LUMBAR EXAM	
Low Back Spasm:	No Right Side Left Side
ROM: Extension of	Platford Right Lateral Flex / Les Lateral Flex / Right Post
	agth: Right/ Left Lower Extremity
SLR: (4) on (5)	•
Palpatory Tenderness:	: L-Spine: 1 2(3)(4)(5)
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INITIAL I	MPRESSION D	<u>IAGNOSIS</u>		
HSprainLh	pament Injury			
I/Spraint Li	gament lajary	•		
Radicalita	Radiculopathy: R	©		,
L Radiculie	Radiculopathy: F	D		
Hendaches:	>			
Dizziness: Y	/N Tinn	itup; Y/N		
Shoulder Pai	in: PA			and the second s
Elbow Pain:	R/L			-
Knee Pain: 1	R/L			
Ankle Pain:	R/L		T	
Foot Pain:	R/L	•	,	
DISABILE	<u>LX</u>		, 	
Employment	(Yes) No			
Restrictions:				
Household	/	•	•	
Attendant Ca				
Transportation	•			
	ENDATIONS			
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1.	Back School:
1	Home Treatment (ice, heat):
	Back Support:
1	Neek Support:
	Menipulation: (19 1/5) 1/5
	Moist Hot Packs: (S) T(S) (S)
	Ice Paelo: C/S T/S L/S
	Therepeutic Exercises: Williams Machenzie Exercises Shoulder Shrugs Shoulder Squeezes Wall Walks (shoulder) E/S Flox Ext-Rol-Lat Flex
	Further Diagnostic Tests: 405 - mr.
	GOALS
	Decrease Pain:
	Increase Pain Mobility:
	Increase Strength:
	Restore Activities of Daily Living:
	Initiation of Independent Home Exercises Program:
	PROGNOSIS
	Good/Engrated Poor:
	Will Depend on Farther Testing:
	Will Depend on Further Treatment:
	Awaiting Test Results:
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STATE FARM INSURANCE P.O. BOX 2361 BLOOMINGTON IL 61702-2361

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C. EMPLOYER'S N	AME OR SCHOOL	NAME			G.	OTHE	*****	CIDENT?		- —	c. INSURA	NCE P	LAN NA	ME OR	PROG	RAM NU	JMBER
								YES	[X] NO	STAT	E FA	RM II	NSUF	RANC	E	
d. INSURANCE PL	AN NAME OR PRO	GRAM N	MAME		10	10d. RESERVED FOR LOCAL USE					d. IS THER	E ANC	THER	HEALTI	1 BENE	FIT PLA	IN?
BCBSM									☐ X YES	: [NO	H ye	es, retur	to and c	omplete item 9 a-d.		
12. PATIENT'S OR	AUTHORIZED PFF	SON'S	SIGNAT	URE IN	thre	horize the release of any medical or other information										IGNATURE	
necessary to proc assignment below	833 mis Gam. I also re	quest pe)	ment of	government	ben	efits ei	ther to	myself or to	the p	arty who accepts			nent of medical benefits to the undersigned physician or ices described below,				
	IATURE ON I	:II E						04	i ne	/ 2000							
				·			ATE_			/ 2009	SIGNED			•			
14. DATE OF CURRE	INJURY	(Accident)OR	1		IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS											COCCUPATION
17. NAME OF REFER	PREGNAL OR					GIVE FIRST DATE 12 22 2008					FROM TO						
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19, RESERVED FO	R LOCAL USE	•		17	p. I). NPI					FROM TO 20. OUTSIDE LAB? \$ CHARGES					<u>i</u>	
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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-lault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare caim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS iscal intermediary as the full charge. and the patient is responsible only for the deductible, consurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare camer or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by hts/her employee, 2) they must be an integral, although incidental part of a covered physician's service. 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, littled, 'Carrier Medicare Claims Record,' published in the Federal Rogister, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28. 1990. See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to Issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Attains, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party tability, coordination of benefits, and civil and criminal litination related to the operation of CHAMAD 19. criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed Delow, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, viouid delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches. MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claimwill be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB According to the Paperson's reducion Act or 1995, no persons are required to respond to a collection of information unless it displays a valid OWB control number of this information collection is essentiated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection if you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer 7500 Security Boulevard, Baltimore, Waryland 21244-1860. This address is forcomments and/or suggestions only DONOT WAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

	INITIAL REPORT
	Patient Name: Redacted . Claim Number:
	Date of Birth: 30A974715
	Date of Accident: 4/4/09 Statufarm
	foitial Evaluation Date:
	RISTORY OF CURRENT CONDITION
	Date of Object: 4-4-09 PT. Desvine AT important michagen arc, AT A Red light, was read-ended by
	Drewick ormen, march council then to but
j	Field soon, but was carput. wout to
	Front Seal Back Seat: Police Trappen made a report, want the
	Airbag Deployment: Yes/No Sim people, show released.
	Wearing Seatbell: (Yea) No
	Type of Auto: Van/Truck/Sedan
	Type of Other Vehicle Involved:
	Type of Collision: Front End Rear End Driver Side/ Passenger Side
	Did Vehicle Hit anything Else after Collision? CALIN FRONT OF HER.
	Primary Cause of Collision: Reak ender.
	Amount of Domage to Vehicle; Unisched
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	Body Injuries in Vehicle: Head on Steering Wasel/ Dashboard	
	Loss of Consciousness: NO	
	Immediate Pain after Collision: (Yes) No! Mours Later! Next Day	
	Police Came to Scene: Yes/No - want to spartford on mouse a sequest	
	EMS came to scene: Yes/No	
	Transportation to Hospital by Ambulance: Yes/No	rate and the same
	Anyone Other than Ambulance?	
	Emergency Room Treatments Krays (CT Scan) MRIAMedicine) Admitted/	
-	Released Kept for Observation	
	Follow Up: Doctor's/ Testing NoviC	
	SYMPTOMS	
	Neck Pain (Mid Back) for Back Pain	
	Unner Extremity	
	Numbrales (Ingline Cold Right Left) Both Hands: Pingers	
	Lema E. d.	
	Lower Extremity Numbress/ Tingling/ Cold / Right/ Left/ Both Buttocks/ Feet/ Toes	
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Headaches: Yes/No Dizziness/ Memory Loss:

Frequency:

Duration:

Bowel Bladder Dysfan:

Jew Pain/ Tinnitus:

Hend Pain/ Elbow Pain (R/L)/ Knee Pain(R/L)/ Ankle Pain (R/L) / Foot Pain (R/L)
SHOULEGE PAIN (L)

Abdominal Pain: Location:

Chest Pain: Location:

PREVIOUS MEDICAL HISTORY

Asthma/ Dishetes/ Cancer/ Hypertension/ Heart Disease/ High Cholesterol:

Other:

Acute/ Chronic Medical Condition:

Previous Surgeries: Hen A - byn an. Arvan nemanic.

Previous Auto/ Work Accidents: NONE

Year:

Treatment for Auto/ Work Accident: MRI/ CT/ Surgeries

Resolved/ Not Resolved:

SOCIAL HISTORY

Married/ Divorced/ Widowed/ Single Separated

Chlidren:

Ages:

Live At Home! Away:

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9-atra V- 1955			
Smoke: Yes/No) How much: EMPLOYMENT	Alcohol: Yes/(v) How much:	Recreational Drugs: Yes (10) How much:	
Employed at the time of Ac	ocident: Yes/No		
Currently Employed: Yes	No		.
Date of Last Employment:	hovensur. 08		
Employer: PF CHANGS			
Job Title: Security			
Other:	-		
PHYSICAL EXAM-AP	PEARANCE		
Male/ Cemaki			
White/ Black:			
Reight: 5'5			
Weight: 20			
Right Handed Left Handed)		
Difficulty Standing Yes No Notes:			Marketin
	+		

Difficulty Getting In/Out of Chair: (es) No Notes: NECK EXAM: Nock Spanns: (es) No Right Side Left Side Suboccipitals ROM: Extension Flexion (Right Lateral Flex) (Left Lateral Flex) (Right Left Upper Extremity Decrease Grip Strength: Right Left Upper Extremity Cervical Compression Test: (+)
ROM: Extension Flexical (Right Lateral Flex) Left Lateral Flex) Right Left Romanical Decrease Muscle Strength: Right Left Upper Extremity Decrease Grip Strength: Right Left Upper Extremity Cervical Compression Test: +
Decrease Muscle Strength: Right/ Left Upper Extremity Decrease Grip Strength: Right/ Left Upper Extremity Cervical Compression Test: + Cervical Distraction Test:
Decrease Grip Strength: Right/ Left Upper Extremity Cervical Compression Test: +
Cervical Compression Test: (+)
Cervical Distraction Test:
Shoulder Depression Test:
Valuaiva's Test: 6/-
Palpatory Tenderness:
C-Spine: 负负 (3)(3)(3)(4)(5)(5)(5)(5)(5)(5)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)
LUMBAR EXAM
Low Back Spann YES/No (light Side Side
ROM: Extension Flexion Right Cateral Flex Left Cateral Flex Right Trett
Decrease Muscle Strength: Right/ Left Lower Extremity
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Almatory Tenderness: L-Spine: 1 2 3 4 5

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.,	INITIAL IMPRESSION DIAGNOSIS Copyring Ligament Injury
	Sprain Ligament Injury
:	Sprain Agament lajury
!	Radiculitis Radiculopathy: RIL
	L Radiculitis/ Radiculopathy: R/L
	Hendaches: YS Dizziness: Y/N Timpitus: Y/N
	Shoulder Pain: RVL
	Elbow Pain; R/L
	Knee Pain: R/L
	Ankle Pain: R/L
	Foot Pain: R/L
	DISABILITY
	Employment: Yes No
	Restrictions:
	Household: (Ye)/ No Attendant Care:
	Transportation: Yes/ No
	RECOMMENDATIONS
Ì	X-rays: (/8) (78) (L/8)
	6

Buck School: Home Treatment (ice, best): Back Support: **Neck Support:** Manipulation: (C/S) T/S (C/S) Moist Hot Pucks: OS TAS OS ler Packu: C/S T/S L/S Therapeutic Exercises: Williams/ Mackenzie Exercises/ Shoulder Shrugs/ Shoulder Squeezes/ Wall Walks (shoulder)/ E/S Fiex-Ext-Rot-Lat Flex Further Diagnostic Tests: to & thop **GOALS** Decrease Pain: X Increase Pain Mobility: 🗸 Increase Strength: \bigvee Restore Activities of Daily Living: X. Initiation of Independent Home Exercises Program: X **PROGNOSIS** Good/ Guarded Poor: Will Depend on Further Testing:X Will Depend on Further Treatment: 1 Awaiting Test Results: Hospin A. X-Roof HUMA COTSIGN

STATE FARM INSURANCE P.O. BOX 2361 BLOOMINGTON IL 61702-2361

HEALTH INSURANCE CLAIM FORM

Debt			AMPUS		HAMPVA	GROUP HEALTH	PLAN_BLK	UNG	1a. INSURED'S I.D. 22A974715	NUMBE	R	(FOR	PROGRAM IN ITEM 1)
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BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a fivedicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CHAMPUS participation cases, the physician agrees to accept the charge determination to the health plan or agency shown. In Medicare and the patient is responsible only for the deductible, consurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare camer or CHAMPUS fiscal intermediary at this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)
I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were turn-shed incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS

For services to be considered as "inclident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service. 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Scrvices or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

(PHIVACY ACT STATEMENT)
We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs, Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Rogister, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Fob. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to Issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Attairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA: to the Dept of Justice for representation of the Secretary of Detense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party hability, coordination of benefits, and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in detay in payment or may result in denial of claim. With the one exception discussed DISCLOSURES: Voluntary, nowever, tailure to provide information will result in detay in payment or may result in denal of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the mudical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Compute" Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

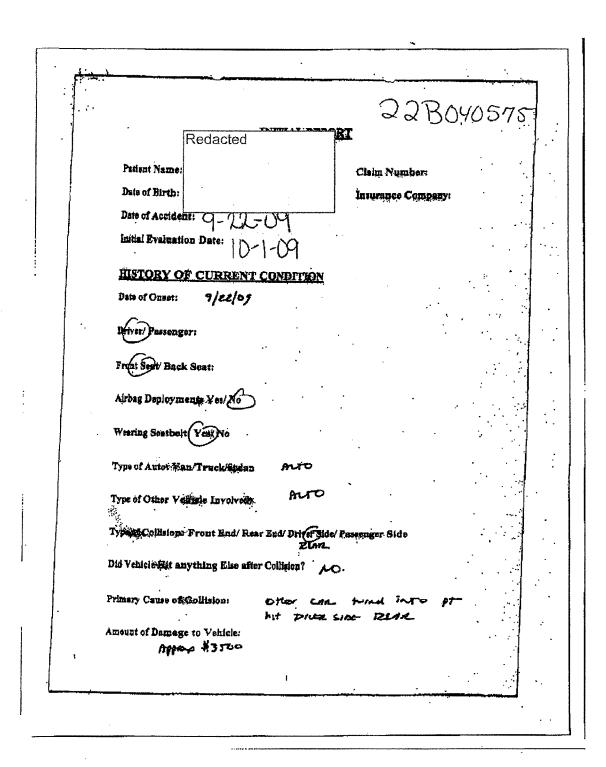
I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally turnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claimfwill be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OWB control number. The valid OWB According to the Paperwork Heduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid ONB control number. The valid ONB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please white to: CMS, Attn. PRA Reports Clearance Officer. 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DONOT WALL COMPLETED CLAIM FORMS TO THIS ADDRESS.



Body Injuries in Vehicle: Head on Steering V	Wheel/ Dashboard -cZ
	DOA HOT-
Immediate Pain after Collision: Yes/ 100 Hou	rs Later/ Next Day
3 00	rs later.
Police Came to Scene Yes No	
EMS came to scene: Yes/ 16	
Transportation to Hospital by Ambulance: Ye	es/ No
Anyone Other than Ambulance?	
Emergency Room Treatment: Xrays/CT Scar Released/Kept for Observation	n/ MRI/ Medicine/ Admitted/
# 4 T/ # - 4 .	pr may Alore At Ibna.
SYMPTOMS // UT	
Neck Pain/ Mid Back/ Low Back Pain	(1) LPT SI
Upper Extremity	LFF SIME CAP
Numbress/Tingling/Cold/Right/Left/Both Hands: Fingers:	(2) UST SION HEADS
	(3) sury pame (5) an
Lower Extremity	in items
Numbness/ Tingling/ Cold / Right/ Left/ Both Buttocks/ Feet/ Toes	(SIPT Neck.
Buttocks/ Keep Toes	On alla NL INTO
110	(6) NO SPASS 2
2	(1) MA SOURE 2

Headaches: VestNo Frequency: pM/ Duration: Cors.
Bowel/ Bladder Dysfxn:
Jaw Pain/ Tinnitus:
Head Pain/ Elbow Pain (R/L)/ Knee Pain(R/L)/ Ankle Pain (R/L) / Foot Pain (R/L)
Abdominal Paln: Location: Spis
Chest Pain: Location:
PREVIOUS MEDICAL HISTORY
Asthma/ Diabetes/ Cancer/ Hypertension/ Heart Disease/ High Cholesterol:
Other:
Acute/ Chronic Medical Condition:
Previous Surgeries: Hyskoctomy 12ht books lung, 6mi Blasco
Previous Auto/Work Accidents: Sty PMI 2003 indust the Dis / seaper.
Treatment for Auto/ Work Accident: MRU CT/ Surgeries
Resolved/ Not Resolved:
SOCIAL HISTORY
Married Divorced/ Widowed/ Single/ Separated
Children: Ages: Live At Home/ Away:
tion of thosping t

Smoke: Yes No How much: | MCK. EMPLOYMENT

Alcohol: Yes/ No

Recreational Drugs: Yes

Employed at the time of Accident: Yes/ No

Currently Employed: Yes/No

HAS NOT RETURNETO WORL STACE

ACE 11).

Date of Last Employment:

Employer: NAT. COUNCIL ON MICOLOL + DING DEPENDENCY

Job Title:

Prevention specific

Other:

compating.

PHYSICAL EXAM-APPEARANCE

Age: 54

Male/ Peparto:

White/ Black:

Height: 53

Weight: 152

Right Handed/ Left Handed:

Difficulty Standing: Yes No Notes:

4

Difficulty Getting In/Out of Chair: Yes No Notes: NECK EXAM:
Neck Spasms: Yes/ No Right Side/Left Side/ Suboccipitals
ROM: Extension / Fraint Right Lateral Flex / Keft Lateral Flex / Right Left Rotation To Pan In New At Min Con All Dickers
Decrease Muscle Strength: Detry Left Upper Extremity
Decrease Grip Strength: Left Upper Extremity
Cervical Compression Test:
Cervical Distraction Test:
Shoulder Depression Test:
Valsalva's Test: +/-
Palpatory Tenderness:
C-Spine: (1 2 3 4 6 6 6 7 9 10 11 12
LUMBAR EXAM
Low Back Spassa: Yes/No Right Side/Left Side
ROM: Extension/ Elexion/ Right Laters Flex/ Lateral Flex/ Right/Left
Decrease Muscle Strength: Right/ Left Lower Extremity
SLR/10
Paipatory Tenderness: L-Spine: 1 2 SEC (DSI)
Scrok pan

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				1
INITIAL IMPRESSION DIAGNOSIS	•			
C/Sprain/Ligament Injury			·	
T/Sprain/Ligament Injury				
L/Sprain/ Ligament Injury				
C Radicultis/Badiculopathy: R/L		·		
L Radiculiys/ Radiculopathy: R/K)				
Head sohes:				1
Dizzlaese: Y/N Tinnitus: Y/N				
Shoulder Pain: R/L				
Elbow Pain: R/L				1
Knee Pain: R/L	-			
Ankle Pain: R/L				1
Foot Pain: R/L		-		"
DISABILITY				
Employment: Yest No				
Restrictions:				
Household: Ves No				
Attendant Care:				
Transportation: Yes/No				1
RECOMMENDATIONS				
X-rays: C/S (T/S (L/D 7U				
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	Back School:	
	Home Treatment (Ce, heat): 1) Method At 15 Ms	
	Back Support:	
	Neck Support:	
	(\mathcal{L})	
	Manipulation: (C/S 1/S L/S	
	Moist Hot Packet CIS TVS LIS	
	Ice Packs: C/S T/S L/S	
	Therapeutic Exercises: Williams/ Mackenzie Exercises/ Should	er Shrugs/Shoulder
	Squeezes/ Wall Walks (shoulder)/ E/S Flex-Ext-Rot-Lat Flex	
	Further Diagnostic Tests:	
	GOALS	
	Decrease Pain:	
	Increase Pain Mobility:	
	Increase Strength:	
	Restore Activities of Daily Living:	
	. 1	
	Initiation of Independent Home Exercises Program:	
	PROGNOSIS	
	:	
=	Good/ Guarden/ Poor:	
	Will Depend of Further Testing:	
	Will Depend on Further Treatment:	
	Awaiting Test Results:	
	Transfer of the second of the	
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	·	A Company of the Comp

STATE FARM INSURANCE P.O. BOX 2361 BLOOMINGTON IL 61702-2361

whcfa150

			H	HEALTH IN	ISURANCE	CLAI	MF	DRM	2
1. MEDICARE MEDICAID CHAMPUS	S CHA	MPVA GROUP	FEC	A OTHER	1a. INSURED'S I.C	. NUMB	ER	(FO	R PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Spanser's	SSN) \ (VA	File #) X (SSN c		SN) [](ID)	22B040575	i			
2. PATIENTS NAME (Lest Name, First Name, Middle			BIRTH DATE	\$EX	4_INSUBED NAME	(Lest N	me. Fin	st Name,	Middle Initial)
Redacted		□[_]Reda	cted M	F X	∐Redacted				
		6. PATIENT	спома	TO INSURED	7				
		Self [X]	Spause Chile	Other 🗌					
· ·		8. PATIENT S	TATUS		ld				
		Single [Married X	Other [<u> </u>
		Employed -	- Full-Time r-	¬ Part-Time (¬¬	2				
<u> </u>			Student	Student [_]	11. INSURED'S PO	NIOV O	DOLLO !	OD CC	- A NUMBER
		I III. IS PATIEN	II S CONDITIO	M RELATED TO.	NONE	JLIG! G	NOUF	OK FE	JA NUMBER
- Constitution of the cons		Ha EMPLOYME	NT2/CURREN	IT or PREVIOUS)	a. INSURED'S DA	TE OF B	RTH		SEX
		11		NO	Reda				M F [X]
		b.AUTO ACCI		PLACE (State)	b. EMPLOTERO		•••••	OOL NA	
		11]NO					
C. EMPLOYER'S NAME OR SCHOOL NAME		c.OTHER ACC		ـــا -	c. INSURANCE PL	AN NAN	E OR	PROGE	RAM NUMBER
1			YES X) NO	STATE FA				
d. INSURANCE PLAN NAME OR PROGRAM N	AME	10d. RESERV	ED FOR LOCA	AL USE	d. IS THERE AND	THER H	EALTH	BENE	FIT PLAN?
TOTAL HEALTH CARE USA					IN	NO			to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S S	SIGNATURE	authorize the release	e of any medical (or other information					ON'S SIGNATURE on undersigned physician or
necessary to process this claim. If also request pays assignment below.					supplier for serving				The state of the s
SIGNED SIGNATURE ON FILE		5.4TF	12 / 09	/ 2009	SIGNED SIG	IITAN	RE O	N FII	ıF
14. DATE OF CURRENT ILLNESS (First syn	notomi AB	DATE			SIGNATURE ON FILE 15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
: : INJURY (Accident)	OR	GIVE FIRST DAT			FROM TO			i i	
PREGNANCY (LN 17. NAME OF REFERRING PHYSICIAN OR OTHER S		17a.			<u> </u>	ON DATE:	RELAT		CURRENT SERVICES
		176. NPI			FROM :	;		TO	
19. RESERVED FOR LOCAL USE					20. OUTSIDE LÁB	?	\$ (CHARC	SES
					YES [X]	NO		\$	0.00
21. DIAGNOSIS OR NATURE OF ILLNESS OR	INJURY. (RE	LATE ITEMS 1,2,3 OF	R 4 TO ITEM 24E	BY LINE)	22. MEDICAID RE	SUBMIS	SION	GINAL	REF. NO.
1. 847 0	3. 847	7 2							AAR 900 0
0.047.4	. 701				23. PRIOR AUTHO	RIZATIO	וטא אכ	WBER	
2. 847 1 24. A B	4. 72 3) 4		E E	F	G	н	J	T
DATE(S) OF SERVICE PIRCE		CEDURES, SERVICES	OR SUPPLIES	DIAGNOSIS			EPSOT Family	I.D.	RENDERING
From To of Service	EMG CPT/	(Explain Unusual Circ HCPCS] MODIFI	iER	POINTER	\$ CHARGES	UNITS	Pian	QUAL.	PROVIDER ID. #
10 01 09 10 01 09 11	992	205 :		1	250.00	1		NPI	4404072007
								1412-1	1104973007
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10 15 09 10 15 09 11	970	10 59		1	35.00	1		NPI	1104973007
									110401001
10 15 09 10 15 09 11	989	141		1,2,3,4	75.00	1		NPI	1104973007
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT	S ACCOUNT NO.	27. ACCEPT A	SSIGNMENT?	28. TOTAL CHARGE	12	9. AMOL	JNT PAI	D 30. BALANCE DUE
205918486 [X]	00001		[X] YES	□ №	\$545.	3		\$98.	.
31.SIGNATURE OF PHYSICIAN OR SUPPLIER		ADDRESS OF FACI	LITY WHERE SE	,		PLIER'S	BILLING	NAME.	ADDRESS, ZIP CODE
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		D (If other than home RSAL HEALTH		NC I	PHONE # UNIVERSAL	HEAL1	TH GF	ROUP	, INC.
apply to this bill and are made a part thereof.)	1	V. 12 MILE RC			5761 WEST N				-
DAVID KATZ	1	FIELD MI 480:			WEST BLOO	MFIEL	D MI	48322	248 626-6892
SIGNED DC 12/09/2009	158883	2653			15888	332653	3		

PLEASE PRINT OR TYPE

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation of any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare craim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the national is responsible only for the deductible. Consulance and noncovered services. Consulance and the fediticible are based upon the charge and the patient is responsible only for the deductible, consurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carner or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were turnshed incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by those programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosuros are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. 'Republication of Notice of Systems of Records.' Federal Register Vol. 55 No. 40, Wed Feb. 28. 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

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UHG-DET DOA: 11/29/2011
DATE: 129 2011 DAILY TREATMENT FORM (TI) CHIROPRACTIC DOB: 48158
PATIENT NAME LAST: Redacted FIRST:
SUBJECTIVE: SEVERITY SCALE 1-10 (EXCRUCIATING) Type of complaint: Lefeft Reright Weweakness Nenumbness Tetingling Sesharp Alachy Dedull Behaving Ceconstant Fefrequent Oeoccasionally
HEAD FACE JAW TILD UPPER BACK MIDBACK SHOULDER ARM ARM WRIST HAND BUTTOCK HIP TOOMHIGH KNEE
NOTES: 7 HOLS YOUR CLAY OF FROM B What goes dern broth lat
OBJECTIVE: FIXATED SEGMENTS: C1/C2/C3/C4/C5/C6/C7/11/12/13/14/15/18/17/18/19/11/11/11/11/11/13/14/15/18/KSI/LSI
PALPATION FINDINGS: L=left R=right T=tenderness S=spssm L R T S Suboccipitals L R D Posterior cervicels L R I S Erector spinae L R S Quadratus lumborum L R S Pkriformis
NOTES:
ASSESMENT: Guarded Continue - no change As expected Exacerbation of condition Mild Improvement Moderate Improvement Other:
Adjustment: OCC/C1/C2/C3/C4/C5/C6/C7/T1/T2/T3/T4/T5/T8/T7/T8/T9/T10/T11/T12/L1/L2/L3/L4/L5/S/RSI/LSI Extra Spinal: L/R shoulder L/R elbow L/R wrist L/R hand L/R knee L/R ankle foot Other:
NOTES:
Difference of the control of the co
SERVICES OR SUPPLIES RENDERED PI.
Init. NEW PATIENT EXAM Init. MODALITIES Init. X-RAY EXAMINATION Init. MISCELLANEOUS SERVICES
CPT CODE (98941): This is a manual spinal adjustment of up to 4 regions. Performed by hand (full spine). Thompson Drop Technique which the patient is adjusted by hand and the table drops from underneath the patient or Activator Technique in which a handheld instrument is used to adjust the patient. These adjustments remove vertebral fixations (subtuxations) and realign the vertebrae of the spine. CPT CODE (97010-59): Hot/Cold pack used to relax the tissue. It mobilizes edematous fluid, increased blood flow and reduces muscle spasms CPT CODE (97012-59); Intersegmental Mechanical Traction. Each vertebra is tractioned out separately. This improves the biomechanics of the vertebral structure. In doing so it helps promote the return of the normal/natural spinal curvature.
Referred To/For:
DISCLOSURE AND ACKNOWLEDGEMENT I attest to the fact that the above services were rendered and they were explained to me and I agree and give my complete informed consent to continue as the doctor feels necessary. I am aware my file is available for review Redacted Treating physician: (partition and signature provided in the provided

		-
	UNIVERSAL HEALTH GROUP-DET	: : : :
Dinitial exam	Physical Examination	0 ()
Mitial exam Redacted	Physical Examination Redacted	
Patient Name (last):	Flrst:	Age: Female
leight: 100 ib		
Height: Weight: OO ib	Paipation: TANNL	Spinal Paipation
Gait:	□ Skin, temperature, moisture:	
kin (bruising, scars):	Example 2 Parolids, thyroid, lymph nodes:	C2
) interior	Lypain (article)	c3
	Depart (s)	C4
Sensation ONP L R	U edema (e)	C6
tight touch	O METP (I) (PROSE SERVICE)	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Sharp/dull	U sche (a) U burning (b)	†2
Vibration	U tingling (I)	31.164/2
Reflexes (0-5) ONP L R	A COLOR OF THE COL	B TO THE STATE OF
Biceps (C5)(musculoculaneous)		
Brachioradialis (C6)(radial)		7
Triceps (C7)(radial)	4 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	19 110
Patellar (L4)(femoral)		NUMBER TIT
Medial hamstring(LS)(sciatic)		T12
Achilles (S1)(tibial)		12
Babinski	AND THE STATE OF T	13
Other:		1/ 15
CHI WNL		srx srx
Headaches Dizzy		SI
Blurred vision Sleep disturbance Tinnitus Memory loss	distant in the second s	
Nausca/vomiting Photosensitivity	Orthopedic exam: c WNL, o other:	and the same of th
Resisted neck ROM (C1-C4) Shoulder elevation (CN XI, C3-C6) Shoulder abduction (C4-C6) Eibow flexion (C5-C6) Eibow extension (C6-C8) Wrist/finger flexion (C7-T1) Wrist/finger extension (C6-C8) Hip flexion (L1-L3) Knee extension (L2-L4) Knee flexion (L4-S1) Plantar flexion (L5-S2) Oorsiflexion (L4-L5) Other	Had welk (L3, L4, L5) Toe walk (S1) Tandem Romberg Romberg Other: Stoulder Depress Flexion (45") Extension (55") Laterat flexion (45") Rotation (70")	Kemp's test SLR passive, active Braggerd's Patrick's (FABERE) Thomas/Geensien's Valsativa SI distraction/compression Flexion (90") Extension (30") Leteral Edixion (20") Rotation (30")
dented out for side of the least coursed	And Sunt in trud Anderson let the Le un tre Most en the frate his behicle as a result que poet.	DATE: VAJG/2011 DR Madhewall
		古字语言 \$1.5%

UNIVERSAL HEALTH GROUP-DET

U12

DIAGNOSIS FORM

INITIAL EVALUATION RE-EVALUATION Redacted Redacted PATIENT NAME (Last): (First): ICD-9 Description ICD-9 Description **BCBS CODES** 839.00 719.41 Pain in joint, shoulder Closed dislocation cervical vertebra, unspecified 719.46 Pain in joint, lower leg 839.20 Closed dislocation lumbar vertebra 728.5 Pain in limb 1839,21 Closed dislocation thoracic vertebra 786.50 Chest pain, unspecified 839.42 Closed dislocation sacrum vertebra 789.07 Abdominal pain, generalized 840.9 Sprain, shoulder and upper arm MEDICARE CODES 841.9 Sprain, elbow and forearm 739.0 Subluxation, Head region (occipitocervical) 842.00 Sprain, wrist 739.1 Subjuxation, Cervical region 842.10 Sprain, hand **-739.2**. Subluxation, Thoracic region 843.9 Sprain, hip and thigh 739.3 Subluxation, Lumbar region 844.9 Sprain, knee and leg 739.4 Subluxation, Sacral region 845.00 Sprain, ankle 739.5 Subluxation, Pelvis region Spondylosis, cervical w/a myelopathy 845.10 Sprain, foot 721.0 721.2 Spondylosis, thoracic w/o myelopathy 846.9 Sprain and strains, shoulder 721.3 Spondylosis, lumbar w/o myelopathy 847.0 Sprain and strains, neck Spondylosis, unspecified w/o myelopathy 847.1 Sprain and strains, thoracic 721,90 722.4 Degeneration of cervical disc 847.2 Sprain and strains, lumbar Degeneration of thoracic disc 722,51 847.3 Sprain and strains, sacrum Degeneration of lumbar disc 722,52 847.4 Sprain and strains, coccyx Degeneration of unspecified disc 722.56 848.1 Sprain, jaw Disc disorder, unspecified region 722.90 848.5 Sprain, pelvis Disc disorder, cervical region 722.91 920 Contusion, face, scalp, neck Disc disorder, thoracic region 722,92 924.00 Contusion, thigh Disc disorder, lumbar region 722.93 924.01 Contusion, hip Spinal stenosis, cervical 723.0 Tension Headaches 307.81 Spinal stenosis, unspecified 724.00 346.90 Migraine, unspecified Spinal stenosis, thoracic 724.01 358.10 Blurred vision (subjective) Spinal stenosis, lumbar Photosensitivity (visual discomfort) 724.02 368.13 723.1 Cervicalgia Tinnitus, unspecified 388.30 Pain, thoracic spine TMI disorders, unspecified 724.1 524.60 Lumbago Dizziness, vertigo and giddiness 724.2 780.4 724.3 Sclatica Sleep disturbance, unspecified 780.50 Radiculitis, cervical/brachial NOS 723.4 780.79 Fatigue Radiculitis, thoracic or lumbosacral (unspecified) 724.4 780.93 Memory loss Backache (unspecified) 724.5 782.0 Disturbance of skin sensation Laxity of ligament 728.4 784.0 Headache Spasm of muscle 728.85 787.0 Nausea/vomiting Myatgia and myositis (unspecified) 729.1 959.01 Head Injury, unspecified Other

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EALTH INSURANCE CLAIM FORM	DALLAS TX	75266		
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05				
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MEDICARE MEDICAID TRICARE CHAMPVA GROUP CHAMPUS HEALTH PLAN		a. INSURED'S I.D. NUMBER		(For Program in item 1)
(Medicare #) (Medicald #) (Sponsor's SSN) (Mamber ID#) (SSN or ID)	(SSN) X (TD)	22070L262		
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8. PATIENT STATUS				Distance
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Section of FUITE	me Part-Time			
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDI	nt Student			
OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Curre	ant or Provious) a.	L INSURED'S DATE OF BIRTH	7	SEX
YES	X NO	Redacted		<u>x</u>
OTHER INSURED'S DATE OF BIRTH SEX 6 AUTO ACCIDENT?	12102 (0210)). EMPerrent control c	NAME	•
EMPLOYER'S NAME OF SCHOOL NAME c. OTHER ACCIDENT?	NO [MI]	. INSURANCE PLAN NAME OR P	ROGRAM N	IAME
YES	- I	STATE FARM INS		
INSURANCE PLAN NAME OR PROGRAM NAME 10d RESERVED FOR LO	المستنبا	I. IS THERE ANOTHER HEALTH E		
·		<u> </u>		o and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or oth to process this claim. I also request payment of government benefits either to myself or to the party w	ner information necessary	 INSURED'S OR AUTHORIZED I payment of medical benefits to the 	PERSON'S he undersig	SIGNATURE I authorize med physician or supplier for
to process this claim. I also request payment of government benefits either to myself or to the party w below.	the accepts assignment	services described below.		
SIGNATURE ON FILE DATE	12 12 11	SIGNED SIGNATUR	E ON	FILE
	E OR SIMILAR ILLNESS, 16	B. DATES PATIENT UNABLE TO V		URRENT OCCUPATION
DATE OF CURRENT: ILLNESS (First symptom) OR 15. IF PATIENT HAS HAD SAM 11 29 11 PREGNANCY (LMP) 15. IF PATIENT HAS HAD SAM GIVE FIRST DATE MM 11 129 11 11 129 11 129 11 129 11 129 11 129 11 129 12	i i l	FROM DD YY	то	MM DD YY
NAME OF REFERRING PROVIDER OR OTHER SOURCE 178	18	B. HOSPITALIZATION DATES REL	ATED TO	CURRENT SERVICES
ANDREA S MADHERE DC 170. NPI 11545533		FROM	TO	HARGES
7231 7241 7242 7244 7245 72885	1.0	YES X NO	• •	0100
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)		2. MEDICAID RESUBMISSION	RIGINAL RI	
1739.1 a. [739.3	∀	CODE C	namal n	EF. 110.
	23	3. PRIOR AUTHORIZATION NUME	SER	
7.3.9.2 4. L.7.3.9.4 A. DATE(S) OF SERVICE 8. C. D. PROCEDURES, SERVICES, OR S	SUPPLIES E.	F. T G. T	H. 1.	ı .
From To PLACE OF (Explain Unusual Circumstances)	DIAGNOSIS		SOT ID.	RENDERING PROVIDER ID. #
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	XCEPT ASSIGNMENTT 28	B. TOTAL CHARGE 29. A	NPI MOUNT PA	AID 30. BALANCE DUE
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FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. AC R 205918486 X 42550C78946 X SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse UNIVERSAL HEALTH G.)	YES NO S MATION 33 ROUP [650 00 \$ 3. BILLING PROVIDER INFO & PF UNIVERSAL HEAL	MOUNT P/ (24 TH GF	0 00 5 650 00 18) 8894580 ROUP
FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCOUNT NO. 127. ACCOUNT NO.	YES NO S MATION 33 ROUP [650 00 3	MOUNT PA (24 TH GF ER SU	0 00 5 650 00 18) 8894580 ROUP

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a iwedicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health Insurance, liability, no-fault, worker's compensation for insurance which is responsible to pay for the services for which the Medicare caim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Wedicare authorizes release of the information of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge. and the patient is responsible only for the deductible, consurance and noncovered services. Consurance and noncovered services. Consurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)
I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32)

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411,24(a) and 424.5(a) (5), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, hoalth plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974. "Republication of Notice of Systems of Records." Federal Register Vol. 55 No. 40, Wed Feb 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party kability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 11288 of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Compute" Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge,

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 9938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn. PRA Reports Clearance Officer. 7500 Security Boulevard, Baltmore, Maryland 21244-1850. This address is for comments and/or suggestions only DO NOT WAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.